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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1056

CERTIFICATE OF DEATH

Reg. Dist. No.

01049

282

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loveville		c. LENGTH OF STAY IN 1b Rural Loveville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Frank Last Bailey		4. DATE OF DEATH Month January Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1890
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Thomas Bailey		14. MOTHER'S MAIDEN NAME Rosie Guy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-1653	
17. INFORMANT Mrs. Alberta L. Bailey Loveville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic cv disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 16 d.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Mar 3 , 19 57 , to Jan 2 , 19 57 , that I last saw the deceased alive on Jan 2 , 19 57 , and that death occurred at 5:30 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED ACTUAL SIGNATURE J. Roy Guyther M.D. Mechanicsville, Maryland PHYSICIAN'S NAME (Type) J. Roy Guyther M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/57	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph		22d. LOCATION (City, town, or county) (State) Morganza, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn, Md.	
24a. REC'D. BY REGISTRAR DATE 1/7/57		24b. REGISTRAR'S SIGNATURE Glenn Houser	

RECEIVED

JAN 8 1957

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED LLOYD, JAMES	
2. SEX Male	
3. AGE 65	
4. DATE OF BIRTH JAN 15 1892	
5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION LABORER	
7. CAUSE OF DEATH HEART DISEASE	
8. PLACE OF DEATH HOME	
9. DATE OF DEATH JAN 15 1957	
10. SIGNATURE OF DECEASED JAMES LLOYD	
11. SIGNATURE OF WITNESSES JAMES LLOYD	
12. SIGNATURE OF DECEASED'S NEAREST RELATIVE JAMES LLOYD	
13. SIGNATURE OF DECEASED'S PHYSICIAN JAMES LLOYD	
14. SIGNATURE OF DECEASED'S MINISTER JAMES LLOYD	
15. SIGNATURE OF DECEASED'S BURIAL OFFICER JAMES LLOYD	
16. SIGNATURE OF DECEASED'S FUNERAL HOME JAMES LLOYD	
17. SIGNATURE OF DECEASED'S CEMETERY JAMES LLOYD	
18. SIGNATURE OF DECEASED'S BURIAL PLACE JAMES LLOYD	
19. SIGNATURE OF DECEASED'S BURIAL DATE JAMES LLOYD	
20. SIGNATURE OF DECEASED'S BURIAL TIME JAMES LLOYD	
21. SIGNATURE OF DECEASED'S BURIAL LOCATION JAMES LLOYD	
22. SIGNATURE OF DECEASED'S BURIAL METHOD JAMES LLOYD	
23. SIGNATURE OF DECEASED'S BURIAL TYPE JAMES LLOYD	
24. SIGNATURE OF DECEASED'S BURIAL COLOR JAMES LLOYD	
25. SIGNATURE OF DECEASED'S BURIAL SIZE JAMES LLOYD	
26. SIGNATURE OF DECEASED'S BURIAL WEIGHT JAMES LLOYD	
27. SIGNATURE OF DECEASED'S BURIAL HEIGHT JAMES LLOYD	
28. SIGNATURE OF DECEASED'S BURIAL BUILD JAMES LLOYD	
29. SIGNATURE OF DECEASED'S BURIAL COMPLEXION JAMES LLOYD	
30. SIGNATURE OF DECEASED'S BURIAL HAIR JAMES LLOYD	
31. SIGNATURE OF DECEASED'S BURIAL EYES JAMES LLOYD	
32. SIGNATURE OF DECEASED'S BURIAL MOUTH JAMES LLOYD	
33. SIGNATURE OF DECEASED'S BURIAL NOSE JAMES LLOYD	
34. SIGNATURE OF DECEASED'S BURIAL EARS JAMES LLOYD	
35. SIGNATURE OF DECEASED'S BURIAL FINGERS JAMES LLOYD	
36. SIGNATURE OF DECEASED'S BURIAL TOES JAMES LLOYD	
37. SIGNATURE OF DECEASED'S BURIAL HANDS JAMES LLOYD	
38. SIGNATURE OF DECEASED'S BURIAL FEET JAMES LLOYD	
39. SIGNATURE OF DECEASED'S BURIAL LEGS JAMES LLOYD	
40. SIGNATURE OF DECEASED'S BURIAL ARMS JAMES LLOYD	
41. SIGNATURE OF DECEASED'S BURIAL NECK JAMES LLOYD	
42. SIGNATURE OF DECEASED'S BURIAL THROAT JAMES LLOYD	
43. SIGNATURE OF DECEASED'S BURIAL CHEST JAMES LLOYD	
44. SIGNATURE OF DECEASED'S BURIAL STOMACH JAMES LLOYD	
45. SIGNATURE OF DECEASED'S BURIAL LIVER JAMES LLOYD	
46. SIGNATURE OF DECEASED'S BURIAL SPLEEN JAMES LLOYD	
47. SIGNATURE OF DECEASED'S BURIAL PANCREAS JAMES LLOYD	
48. SIGNATURE OF DECEASED'S BURIAL GALLBLADDER JAMES LLOYD	
49. SIGNATURE OF DECEASED'S BURIAL BLADDER JAMES LLOYD	
50. SIGNATURE OF DECEASED'S BURIAL UTERUS JAMES LLOYD	
51. SIGNATURE OF DECEASED'S BURIAL VAGINA JAMES LLOYD	
52. SIGNATURE OF DECEASED'S BURIAL VULVA JAMES LLOYD	
53. SIGNATURE OF DECEASED'S BURIAL CLITORIS JAMES LLOYD	
54. SIGNATURE OF DECEASED'S BURIAL PENIS JAMES LLOYD	
55. SIGNATURE OF DECEASED'S BURIAL TESTES JAMES LLOYD	
56. SIGNATURE OF DECEASED'S BURIAL PROSTATE JAMES LLOYD	
57. SIGNATURE OF DECEASED'S BURIAL SEMEN JAMES LLOYD	
58. SIGNATURE OF DECEASED'S BURIAL URINE JAMES LLOYD	
59. SIGNATURE OF DECEASED'S BURIAL BLOOD JAMES LLOYD	
60. SIGNATURE OF DECEASED'S BURIAL SWEAT JAMES LLOYD	
61. SIGNATURE OF DECEASED'S BURIAL TEARS JAMES LLOYD	
62. SIGNATURE OF DECEASED'S BURIAL SALIVA JAMES LLOYD	
63. SIGNATURE OF DECEASED'S BURIAL SPIT JAMES LLOYD	
64. SIGNATURE OF DECEASED'S BURIAL BOOZE JAMES LLOYD	
65. SIGNATURE OF DECEASED'S BURIAL DRUGS JAMES LLOYD	
66. SIGNATURE OF DECEASED'S BURIAL ALCOHOL JAMES LLOYD	
67. SIGNATURE OF DECEASED'S BURIAL NARCOTICS JAMES LLOYD	
68. SIGNATURE OF DECEASED'S BURIAL ANESTHETICS JAMES LLOYD	
69. SIGNATURE OF DECEASED'S BURIAL POISONS JAMES LLOYD	
70. SIGNATURE OF DECEASED'S BURIAL TOXINS JAMES LLOYD	
71. SIGNATURE OF DECEASED'S BURIAL ANTIGENS JAMES LLOYD	
72. SIGNATURE OF DECEASED'S BURIAL ANTIBODIES JAMES LLOYD	
73. SIGNATURE OF DECEASED'S BURIAL ENZYMES JAMES LLOYD	
74. SIGNATURE OF DECEASED'S BURIAL HORMONES JAMES LLOYD	
75. SIGNATURE OF DECEASED'S BURIAL VITAMINS JAMES LLOYD	
76. SIGNATURE OF DECEASED'S BURIAL MINERALS JAMES LLOYD	
77. SIGNATURE OF DECEASED'S BURIAL TRACE ELEMENTS JAMES LLOYD	
78. SIGNATURE OF DECEASED'S BURIAL NUTRIENTS JAMES LLOYD	
79. SIGNATURE OF DECEASED'S BURIAL ESSENTIALS JAMES LLOYD	
80. SIGNATURE OF DECEASED'S BURIAL SUPPLEMENTS JAMES LLOYD	
81. SIGNATURE OF DECEASED'S BURIAL ADDITIVES JAMES LLOYD	
82. SIGNATURE OF DECEASED'S BURIAL PRESERVATIVES JAMES LLOYD	
83. SIGNATURE OF DECEASED'S BURIAL STABILIZERS JAMES LLOYD	
84. SIGNATURE OF DECEASED'S BURIAL EMULSIFIERS JAMES LLOYD	
85. SIGNATURE OF DECEASED'S BURIAL SUSPENDING AGENTS JAMES LLOYD	
86. SIGNATURE OF DECEASED'S BURIAL THICKENING AGENTS JAMES LLOYD	
87. SIGNATURE OF DECEASED'S BURIAL GELLING AGENTS JAMES LLOYD	
88. SIGNATURE OF DECEASED'S BURIAL BINDING AGENTS JAMES LLOYD	
89. SIGNATURE OF DECEASED'S BURIAL COAGULATING AGENTS JAMES LLOYD	
90. SIGNATURE OF DECEASED'S BURIAL CRYSTALLIZING AGENTS JAMES LLOYD	
91. SIGNATURE OF DECEASED'S BURIAL PRECIPITATING AGENTS JAMES LLOYD	
92. SIGNATURE OF DECEASED'S BURIAL FLOCCULATING AGENTS JAMES LLOYD	
93. SIGNATURE OF DECEASED'S BURIAL ADSORBING AGENTS JAMES LLOYD	
94. SIGNATURE OF DECEASED'S BURIAL CATALYZING AGENTS JAMES LLOYD	
95. SIGNATURE OF DECEASED'S BURIAL INHIBITING AGENTS JAMES LLOYD	
96. SIGNATURE OF DECEASED'S BURIAL ACCELERATING AGENTS JAMES LLOYD	
97. SIGNATURE OF DECEASED'S BURIAL RETARDING AGENTS JAMES LLOYD	
98. SIGNATURE OF DECEASED'S BURIAL PROMOTING AGENTS JAMES LLOYD	
99. SIGNATURE OF DECEASED'S BURIAL INHIBITING AGENTS JAMES LLOYD	
100. SIGNATURE OF DECEASED'S BURIAL INHIBITING AGENTS JAMES LLOYD	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01050

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 13 FilmG209 1-21-57 et

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Utah b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park				c. LENGTH OF STAY IN 1b 1 yr. 5 mos 8/x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Navy Station Hospital, Patuxent River				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 196 East Utah Ave.			
3. NAME OF DECEASED (Type or print) First Ross Middle Corbett Last Barney				4. DATE OF DEATH Month January Day 6 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 March 1915	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Utah	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown (deceased)				14. MOTHER'S MAIDEN NAME Inez Donā			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 4-18-39		17. INFORMANT Wm.H. Vance - Lexington Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot Rt Temporal Region 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 1:15 or m. p. m.		Month, Day, Year 1/6 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Lexington Park, Md.		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Wm.D. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Wm.D. Boyd, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR 1/11/57		24b. REGISTRAR'S SIGNATURE Gland D. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

JAN 15 1957

RECEIVED

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INSTRUCTIONS

1. **PENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1058 CERTIFICATE OF DEATH

01051

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mechanicsville</u>				TOWN <u>Mechanicsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>RFD Rural</u>				<u>RFD Rural</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u> (Middle) <u>Blake</u> (Last)				(Month) <u>Jan.</u> (Day) <u>4</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>colored</u>	<u>married</u>	<u>1882</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>farming</u>		<u>Farm</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Blake</u>				<u>Johanna Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>-----</u>		<u>Sarah Alice Blake</u> <u>RFD</u> <u>Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A) <u>Carcinoma of Prostate with</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastases into spine</u>				<u>over 2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>over 1 year</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Died suddenly unattended</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>May 16, 1956</u> , to <u>Jan. 4, 1957</u> , that I last saw the deceased alive on <u>Sept. 25, 1956</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Robert Fuchs</u> <u>Robert F. Fuchs</u> M.D.				<u>Leonardtown, Md.</u> <u>1/7/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>1-7-57</u>		<u>Gallilee Cemetery</u>		<u>RFD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1/8/57</u>		<u>Glean L. Hausler</u>		<u>P.B. Robinson</u>		<u>Leonardtown, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. SEX OF BIRTH

12. AGE OF BIRTH

13. OCCUPATION OF BIRTH

14. CAUSE OF BIRTH

15. DATE OF BIRTH

16. TIME OF BIRTH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. SEX OF BIRTH

20. AGE OF BIRTH

21. OCCUPATION OF BIRTH

22. CAUSE OF BIRTH

23. DATE OF BIRTH

24. TIME OF BIRTH

25. PLACE OF BIRTH

26. DATE OF BIRTH

27. SEX OF BIRTH

28. AGE OF BIRTH

29. OCCUPATION OF BIRTH

30. CAUSE OF BIRTH

31. DATE OF BIRTH

32. TIME OF BIRTH

33. PLACE OF BIRTH

34. DATE OF BIRTH

35. SEX OF BIRTH

36. AGE OF BIRTH

37. OCCUPATION OF BIRTH

38. CAUSE OF BIRTH

39. DATE OF BIRTH

40. TIME OF BIRTH

41. PLACE OF BIRTH

42. DATE OF BIRTH

43. SEX OF BIRTH

44. AGE OF BIRTH

45. OCCUPATION OF BIRTH

46. CAUSE OF BIRTH

47. DATE OF BIRTH

48. TIME OF BIRTH

49. PLACE OF BIRTH

50. DATE OF BIRTH

51. SEX OF BIRTH

52. AGE OF BIRTH

53. OCCUPATION OF BIRTH

54. CAUSE OF BIRTH

55. DATE OF BIRTH

56. TIME OF BIRTH

57. PLACE OF BIRTH

58. DATE OF BIRTH

59. SEX OF BIRTH

60. AGE OF BIRTH

61. OCCUPATION OF BIRTH

62. CAUSE OF BIRTH

63. DATE OF BIRTH

64. TIME OF BIRTH

65. PLACE OF BIRTH

66. DATE OF BIRTH

67. SEX OF BIRTH

68. AGE OF BIRTH

69. OCCUPATION OF BIRTH

70. CAUSE OF BIRTH

71. DATE OF BIRTH

72. TIME OF BIRTH

73. PLACE OF BIRTH

74. DATE OF BIRTH

75. SEX OF BIRTH

76. AGE OF BIRTH

77. OCCUPATION OF BIRTH

78. CAUSE OF BIRTH

79. DATE OF BIRTH

80. TIME OF BIRTH

81. PLACE OF BIRTH

82. DATE OF BIRTH

83. SEX OF BIRTH

84. AGE OF BIRTH

85. OCCUPATION OF BIRTH

86. CAUSE OF BIRTH

87. DATE OF BIRTH

88. TIME OF BIRTH

89. PLACE OF BIRTH

90. DATE OF BIRTH

91. SEX OF BIRTH

92. AGE OF BIRTH

93. OCCUPATION OF BIRTH

94. CAUSE OF BIRTH

95. DATE OF BIRTH

96. TIME OF BIRTH

97. PLACE OF BIRTH

98. DATE OF BIRTH

99. SEX OF BIRTH

100. AGE OF BIRTH

101. OCCUPATION OF BIRTH

102. CAUSE OF BIRTH

103. DATE OF BIRTH

104. TIME OF BIRTH

105. PLACE OF BIRTH

106. DATE OF BIRTH

107. SEX OF BIRTH

108. AGE OF BIRTH

109. OCCUPATION OF BIRTH

110. CAUSE OF BIRTH

BUREAU V. 3

JAN 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0105282

1059

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt: # 5 Leonardtown,				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Wynn			
				d. STREET ADDRESS Rural			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Herbert Last Gullison				4. DATE OF DEATH Month Jan. Day 4 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alonso Cullison				14. MOTHER'S MAIDEN NAME Daisy Langley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-10-6738		17. INFORMANT Dorothy Dunbar - Wynn, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Posterior Coronary Occlusion DUE TO (b) 20 min Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/4/57			
EXAMINER'S NAME (Type) William D. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/7/57	22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	22d. LOCATION (City, town, or county) (State) St. Marys City, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.			ADDRESS		24a. REC'D BY REGISTRAR 1/8/57	24b. REGISTRAR'S SIGNATURE Glen D. Houser	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JAN 9 1957

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

Item 20 Film 210 1-29-57

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Washington Fenwick		4. DATE OF DEATH Month Day Year January 13, 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1903
9. AGE (In years, months, days) 53 yrs. 9 mos. 27 days		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Fenwick		14. MOTHER'S MAIDEN NAME Beckie Lawrence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mary Agnes Edgston Great Mills, Md.	
17. INFORMANT Mary Agnes Edgston Great Mills, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broken Neck DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 825X (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auto accident		INTERVAL BETWEEN ONSET AND DEATH Instantaneous	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1/13/57 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rte #5		20f. (City or town) (County) (State) Calloway St. Marys Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Wm D Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-16-57	
22c. NAME OF CEMETERY OR CREMATORY Our Lady's		22d. LOCATION (City, town, or county) (State) Mdella's Neck, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR 1/15/57	
		24b. REGISTRAR'S SIGNATURE Dean D. Hauser	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 RACE: [illegible] BIRTH DATE: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 MANNER OF DEATH: [illegible]
 SIGNATURE OF EXAMINER: [illegible]
 DATE: [illegible]

BUREAU V. 2
 JAN 16 1957
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01054

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) US NAS PATUXENT RIVER		c. LENGTH OF STAY IN 1b 2 LEXINGTON PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 86 ANDERSON CT.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last TELECFUR JOHN GIBRASKI		4. DATE OF DEATH Month Day Year JAN. 18 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1899
9. AGE (In years last birthday) 58 yrs.		10. BIRTHPLACE (State or foreign country) Illinois	
11. CITIZEN OF WHAT COUNTRY? USA			
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Gibraski		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-09-4452	
17. INFORMANT Mrs. Isabel T. Gibraski		Address 86 Anderson Ct. Lexington Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot Rt Temporal Region DUE TO (b) 976x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William D. Boyd, MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd, MD		DATE SIGNED 1/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hysong Co.		24a. REC'D BY REGISTRAR 1/21/57	
24b. REGISTRAR'S SIGNATURE Glen C. Gausser			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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JAN 22 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01055

1062

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Amanda Middle Grace Last Hebb				4. DATE OF DEATH Month January Day 2 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1891	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME French Abell				14. MOTHER'S MAIDEN NAME Hannah Abell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Mabel Abell Hollywood, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary atherosclerosis							
INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 2, 1957 to Jan 2, 1957 , that I last saw the deceased alive on Jan 2, 1957 , and that death occurred at 5 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1/2/57							
ACTUAL SIGNATURE P.J. Bean M.D.				Great Mills, Maryland			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/57		22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE 1/3/57		24b. REGISTRAR'S SIGNATURE Robert R. Ralston	

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JAN 7 1957

BUREAU A. S.

1063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH o. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATUXENT RIVER				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US NAVY INFIRMARY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EARL Middle WAYNE Last LOHR				4. DATE OF DEATH Month JAN. Day 17 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired carpenter				10b. KIND OF BUSINESS OR INDUSTRY building		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Archie Lohr				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 223-18-5193		17. INFORMANT Mary V. Lohr- California, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (b) Hypertensive Arteriosclerosis (c) heart disease DUE TO heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William D. Boyd, MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) William D. Boyd, MD				DATE SIGNED 1/17/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/57		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Great Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR 1/20/57		24b. REGISTRAR'S SIGNATURE Charles D. Hauser	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please pre-arrange the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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JAN 22 1957

BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01057

1064

CERTIFICATE OF DEATH

Reg. Dist. No.

281

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Gertrude Last Louden				4. DATE OF DEATH Month January Day 5 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 9 Days 30		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John James Pegg				14. MOTHER'S MAIDEN NAME Ellen Kirby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr Albert W. Loudon Great Mills, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crownary accident 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Paralyzed on two occasions DUE TO 10 years (c) Hypertension DUE TO 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Great Mills, Maryland				20g. (County) (State)			
21. I certify that I attended the deceased from May 1946 to Jan 5, 1957 , that I last saw the deceased alive on Jan 5, 1957 , and that death occurred at 4:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Maryland DATE SIGNED 1/6/57							
ACTUAL SIGNATURE P.J. Bean				PHYSICIAN'S NAME (Type) P.J. Bean M.D. Great Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/57		22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Great Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE 1/6/57	
24b. REGISTRAR'S SIGNATURE P.J. Bean							

CERTIFICATE OF DEATH

WESTLAND STATE DEPT. OF HEALTH - BUREAU 10

WESTLAND STATE DEPT. OF HEALTH - BUREAU 10

NAME OF DECEASED John James Perry		AGE 35		SEX Male		RACE White		DATE OF BIRTH 1924		PLACE OF BIRTH London, Ontario, Canada	
MARRIAGE Married		SINGLE		WIDOWED		DIVORCED		DATE OF MARRIAGE 1945		PLACE OF MARRIAGE London, Ontario, Canada	
CAUSE OF DEATH Heart Failure		DISEASE OR INJURY None		MANNER OF DEATH Natural		PLACE OF DEATH Home		DATE OF DEATH 1957		PLACE OF DEATH Home	
SIGNATURE OF PHYSICIAN Dr. Albert W. London		SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]	
DATE OF DEATH 1957		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		DATE OF DEATH 1957		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	

BUREAU V. S.

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01058

1065

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Valley Lee				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2Rural Valley Lee			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First John Middle Mason Last Mason				4. DATE OF DEATH January 2 , 19 56 7			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1891	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 2 Days 17		IF UNDER 24 HRS. Hours 17 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank Mason				14. MOTHER'S MAIDEN NAME Mary Lawrence			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No		17. INFORMANT Mary C. Fenwick Valley Lee, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 hours 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan 2, 1957 to Jan 2, 1957 , that I last saw the deceased alive on Jan 2, 1957 , and that death occurred at 3 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Maryland DATE SIGNED 1/2/57							
ACTUAL SIGNATURE P.J. Bean M.D.							
PHYSICIAN'S NAME (Type) P.J. Bean M.D.				Great Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/57		22c. NAME OF CEMETERY OR CREMATORY Bethesda		22d. LOCATION (City, town, or county) (State) Valley Lee, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, MD.				24a. REC'D BY REGISTRAR DATE 1/3/57		24b. REGISTRAR'S SIGNATURE	

BUREAU A. E.

1957 2 June

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Park Hall d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Robinson Last Robinson		4. DATE OF DEATH Month January Day 25 Year 1957	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1909
9. AGE (In years last birthday) yrs. 48		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Campbell		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mrs Grace G. Barnes Piney Point, Md.	
17. INFORMANT Mrs Grace G. Barnes Piney Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 year			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 1953, to Jan 25 , 1957, that I last saw the deceased alive on Jan 24 , 1957, and that death occurred at 1009 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1/25/57			
ACTUAL SIGNATURE William D. Boyd M.D.		PHYSICIAN'S NAME (Type) William D. Boyd M. D. Leonardtwn, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/57	
22c. NAME OF CEMETERY OR CREMATORY St. Lukes		22d. LOCATION (City, town, or county) (State) Piney Point, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE 1/25/57	
24b. REGISTRAR'S SIGNATURE W. Clarke Mattingley			

BUREAU V. S.

JAN 28 1957

RECEIVED

1

INSTRUCTIONS

1. **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01060

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u>		STATE <u>Maryland</u> COUNTY <u>St. Marys</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtwn</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Great Mills</u>	
TOWN <u>Leonardtwn</u>		LENGTH OF STAY (in this place)		TOWN <u>Great Mills</u>		STREET ADDRESS (If rural give location) <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Marys Hospital</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Ernie</u> (Middle) <u>Rae</u> (Last) <u>Sparks</u>				Jan. 4 1957			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Dec 20, 1956</u>	9. AGE last birthday yrs. <u>16</u>	IF UNDER 1 YEAR Months Days <u>16</u>		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Sparks</u>				14. MOTHER'S MAIDEN NAME <u>Cleo Sellers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Geo. Sparks - Great Mills, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 days			
763.0 IMMEDIATE CAUSE (A) <u>Broncho pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 2, 1957</u> , to <u>Jan 4, 1957</u> , that I last saw the deceased alive on <u>Jan 4, 1957</u> , and that death occurred at <u>-----</u> M, from the causes and on the date stated above.							
SIGNATURE <u>P. J. Bean</u> M.D. <u>Great Mills, Md.</u>				ADDRESS (Street, city, town, state) <u>14157</u> DATE SIGNED <u>1/4/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Transportation</u>		DATE THEREOF <u>1/5/57</u>		NAME OF CEMETERY OR CREMATORY <u>Coeburn, Virginia</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>1/4/57</u>		REGISTRAR'S SIGNATURE <u>P.B. Robinson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson- Leonardtown, Md.</u> ADDRESS			

4000267XV6

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE

PLACE

TIME

REPORTED BY

SIGNATURE

REGISTRATION NO.

FILE NO.

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. 2

JAN 8 1957

RECEIVED

NOTIFICATION

NOTIFICATION TO BE FURNISHED TO THE NEAREST RELATIVE OR TO THE NEXT OF KIN OF THE DECEASED, OR TO THE PERSON IN CHARGE OF THE BURIAL, AND TO THE LOCAL HEALTH OFFICER, BY THE REGISTRAR, NOT LATER THAN FIVE DAYS AFTER THE DATE OF DEATH. THIS NOTIFICATION SHALL BE FURNISHED TO THE NEAREST RELATIVE OR TO THE NEXT OF KIN OF THE DECEASED, OR TO THE PERSON IN CHARGE OF THE BURIAL, AND TO THE LOCAL HEALTH OFFICER, BY THE REGISTRAR, NOT LATER THAN FIVE DAYS AFTER THE DATE OF DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1068

CERTIFICATE OF DEATH

Reg. Dist. No.

010612

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Middle Last Fanny Philomena Wood				4. DATE OF DEATH Month Day Year January 4, 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Payne				14. MOTHER'S MAIDEN NAME Martha Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Joseph L. Hayden Mechanicsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular dis DUE TO 20 yrs approx (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis with rt hemiplegia				INTERVAL BETWEEN ONSET AND DEATH 12 d.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 1950 to Jan 4 1957 , that I last saw the deceased alive on Jan 4 1957 , and that death occurred at Mechanicsville, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Mechanicsville, Md. 1/4/57 ACTUAL SIGNATURE J. Roy Guyther M.D. PHYSICIAN'S NAME (Type) J. Roy Guyther M.D. Mechanicsville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/7/57		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Morganza, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE 1/8/57	
				24b. REGISTRAR'S SIGNATURE Gladys D. Hauser			

JAN 9 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01062

Reg. Dist. No. 282

1069

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Leonardtwn</u>				TOWN <u>Lexington Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Marys Hospital</u>				STREET ADDRESS (If rural give location) <u># 8 Rosevelt</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Infant Girl Yates</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 3, 19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>1/3/57</u>	9. AGE last birthday yrs. <u>1</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elbert Yates</u>				14. MOTHER'S MAIDEN NAME <u>Willie Lee Strong</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT & ADDRESS <u>Willie Lee Yates - Lexington Park</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A) <u>Prematurity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Vascular Renal Disease of mother.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>of mother.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-3-</u> , 19 <u>57</u> , to <u>1-3-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-3-</u> , 19 <u>57</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. H. Patrick</u>				ADDRESS (Street, city, town, state) <u>M.D. Lexington Park, Md.</u> DATE SIGNED <u>1/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/4/57</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Lexington Park, Md.</u>	
24. REC'D BY REGISTRAR <u>Clara D. Naudery</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson</u>		ADDRESS <u>Leonardtwn, Md.</u>	

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CERTIFICATE OF DEATH

1000

BUREAU V. B.

JAN 9 1957

RECEIVED

RECEIVED
JAN 10 1957
BUREAU OF VITALS
STATE OF NEW YORK